		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016964

Facility Name: Bohannon Nursing Home

Address: 1201 N. Alton (Number) Lebanon (City) 62254 (Zip Code)

County: St. Clair

Telephone Number: (618) 537-4401 **Fax #** (618) 537-4447

IDPA ID Number: 37-0708824-001

Date of Initial License for Current Owners: 04/06/1950

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael J. Hund **Telephone Number:** (618) 566-2341

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Ken Bohannon
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Michael J. Hund, Partner
(Firm Name & Address) Boyce, Hund & Associates
(Telephone) (618) 566-2341 Fax # (618) 566-4220

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,966	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,616	9,797	219	27,632	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,616	9,797	219	27,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.75%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/12/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 255

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	124,063	6,795	4,561	135,419		135,419		135,419			1
2	Food Purchase		109,425		109,425		109,425	(512)	108,913			2
3	Housekeeping	71,222	10,457		81,679		81,679		81,679			3
4	Laundry	28,702	11,637		40,339		40,339		40,339			4
5	Heat and Other Utilities			57,850	57,850		57,850		57,850			5
6	Maintenance	12,131	5,123	21,974	39,228		39,228		39,228			6
7	Other (specify):*											7
8	**TOTAL General Services**	236,118	143,437	84,385	463,940		463,940	(512)	463,428			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	728,299	31,968	29,723	789,990		789,990	(10,375)	779,615			10
10a	Therapy	26,367		60	26,427		26,427	(8,818)	17,609			10a
11	Activities	24,981	1,540	1,209	27,730		27,730		27,730			11
12	Social Services	20,045		1,287	21,332		21,332		21,332			12
13	Nurse Aide Training	4,980	501		5,481		5,481		5,481			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	804,672	34,009	35,279	873,960		873,960	(19,193)	854,767			16
	C. General Administration											
17	Administrative	104,918			104,918		104,918		104,918			17
18	Directors Fees											18
19	Professional Services			71,303	71,303		71,303	(41,030)	30,273			19
20	Dues, Fees, Subscriptions & Promotions			12,674	12,674		12,674	(4,542)	8,132			20
21	Clerical & General Office Expenses	32,785	6,082	7,312	46,179		46,179	(169)	46,010			21
22	Employee Benefits & Payroll Taxes			135,028	135,028		135,028	(6,193)	128,835			22
23	Inservice Training & Education			96	96		96		96			23
24	Travel and Seminar			2,492	2,492		2,492	(1,765)	727			24
25	Other Admin. Staff Transportation			682	682		682		682			25
26	Insurance-Prop.Liab.Malpractice			11,702	11,702		11,702		11,702			26
27	Other (specify):*			4,320	4,320		4,320	(4,320)				27
28	**TOTAL General Administration**	137,703	6,082	245,609	389,394		389,394	(58,019)	331,375			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,178,493	183,528	365,273	1,727,294		1,727,294	(77,724)	1,649,570			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bohannon Nursing Home #0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			90,819	90,819		90,819	(35,904)	54,915			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,686	24,686		24,686	(24,686)				32
33	Real Estate Taxes			37,831	37,831		37,831		37,831			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,288	5,288		5,288		5,288			35
36	Other (specify):*											36
37	**TOTAL Ownership**			158,624	158,624		158,624	(60,590)	98,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			19,269	19,269		19,269		19,269			39
40	Barber and Beauty Shops			6,546	6,546		6,546	(3,386)	3,160			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,450	55,450		55,450		55,450			42
43	Other (specify):*			7,716	7,716		7,716	(7,716)				43
44	**TOTAL Special Cost Centers**			88,981	88,981		88,981	(11,102)	77,879			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,178,493	183,528	612,878	1,974,899		1,974,899	(149,416)	1,825,483			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,763)	30		9
10	Interest and Other Investment Income	(24,686)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(512)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(125)	27		20
21	Owner or Key-Man Insurance	(3,296)	27		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,156)	43		24
25	Fund Raising, Advertising and Promotional	(3,205)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(211)	20		28
29	Other-Attach Schedule	(75,462)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (149,416)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (149,416)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bohannon Nursing Home

ID# 0016964

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Revenue	$ (3,386)	40	1
2	Non-Care Related Depreciation	(141)	30	2
3	Non-Care Related Travel	(1,765)	24	3
4	Medicare Reimbursement	(1,560)	43	4
5	Bank Charges	(169)	21	5
6	Subscriptions, Dues	(1,126)	20	6
7	Marketing	(41,030)	19	7
8	Airplane	(899)	27	8
9	Patient Medical Supply Revenue	(10,375)	10	9
10	Therapy Revenue	(8,818)	10a	10
11	Employee Insurance	(3,366)	22	11
12	Employee Incentives, Meals	(2,827)	22	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(75,462)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bohannon Nursing Home # 0016964 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(512)	0	0	0	0	0	0	0	0	0	0	(512)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(512)	0	0	0	0	0	0	0	0	0	0	(512)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10,375)	0	0	0	0	0	0	0	0	0	0	(10,375)	10
10a	Therapy	(8,818)	0	0	0	0	0	0	0	0	0	0	(8,818)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,193)	0	0	0	0	0	0	0	0	0	0	(19,193)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(41,030)	0	0	0	0	0	0	0	0	0	0	(41,030)	19
20	Fees, Subscriptions & Promotions	(4,542)	0	0	0	0	0	0	0	0	0	0	(4,542)	20
21	Clerical & General Office Expenses	(169)	0	0	0	0	0	0	0	0	0	0	(169)	21
22	Employee Benefits & Payroll Taxes	(6,193)	0	0	0	0	0	0	0	0	0	0	(6,193)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,765)	0	0	0	0	0	0	0	0	0	0	(1,765)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320)	27
28	**TOTAL General Administration**	(58,019)	0	0	0	0	0	0	0	0	0	0	(58,019)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,724)	0	0	0	0	0	0	0	0	0	0	(77,724)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bohannon Nursing Home # 0016964 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(35,904)	0	0	0	0	0	0	0	0	0	0	(35,904)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,686)	0	0	0	0	0	0	0	0	0	0	(24,686)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(60,590)	0	0	0	0	0	0	0	0	0	0	(60,590)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(3,386)	0	0	0	0	0	0	0	0	0	0	(3,386)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(7,716)	0	0	0	0	0	0	0	0	0	0	(7,716)	43
44	**TOTAL Special Cost Centers**	(11,102)	0	0	0	0	0	0	0	0	0	0	(11,102)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(149,416)	0	0	0	0	0	0	0	0	0	0	(149,416)	45

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ken Bohannon	100.00%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ken Bohannon	President	Asst. Administrato	100.00	0	24	60.00	Salary	$ 35,510	Ln 17, Col 1	1
2	Lee Bohannon-Smith	None	Administrator	0.00	0	40	100.00	Salary	69,408	Ln 17, Col 1	2
3	Barry Smith	None	Maintenance	0.00	0	4	10.00	Fees	1,385	Ln 6, Col 3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 106,303		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		Not Applicable								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Small Business Administration		X	Addition Construction	$2,813.00	11/12/86	$ 332,000	$ 153,398	11/12/06	0.0800	$ 13,958	1
2	Bank of O'Fallon		X	Refinance (Construction)	$4,300.00	02/28/99	177,734	100,579	01/31/02	0.0800	10,728	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$7,113.00		$ 509,734	$ 253,977			$ 24,686	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 509,734	$ 253,977			$ 24,686	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	35,789	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	36,810	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,021	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	36,810	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	37,831	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	30,282	8
	1996	32,831	9
	1997	37,342	10
	1998	35,789	11
	1999	36,810	12

Line 2 - Payment applies to calendar year 1999.

Line 4 - Accrual for 2000 is the amount of real estate taxes paid in 2000 for calendar year 1999.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,919 B. General Construction Type: Exterior Brick Frame Concrete & steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	174,240	1972	$ 10,000	1
2					2
3	TOTALS	174,240		$ 10,000	3

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		1972	1972	$ 514,667	$ 12,867	40	$ 12,867	$	$ 360,268	4
5	50		1986	1986	705,125	36,395	40	17,628	(18,767)	254,139	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Equipment			1972	67,551		10			67,551	9
10	Heating System, Air Conditioner			1978	18,296		15			18,296	10
11	Fire Alarm			1980	3,770		25	89	89	3,770	11
12	Fan System			1982	1,388		20	69	69	1,254	12
13	Roof			1983	38,993		25	1,560	1,560	27,815	13
14	Shed & Alarm			1983	7,672		20	384	384	6,564	14
15	Gas Line			1984	694		30	23	23	391	15
16	Heat Pumps			1984	11,561		15			11,561	16
17	Chart System, Windows, Doors			1984	3,847		20	193	193	3,097	17
18	Air Conditioners			1985	1,524		8			1,524	18
19	Water Heaters			1985	3,106		15	189	189	3,106	19
20	Sprinkler System			1986	39,807	2,095	25	1,592	(503)	22,955	20
21	Storage Trailer			1986	1,806		20	90	90	1,354	21
22	Water Heater, Nurse Call			1986	2,025		15	135	135	1,958	22
23	Alarm, Extinguisher, Phones			1986	859		10			859	23
24	Water Heater			1990	2,185		15	146	146	1,542	24
25	Water Heater			1991	2,034		15	136	136	1,232	25
26	Phone, Heater Unit			1992	1,799		10	180	180	1,494	26
27	Air Conditioner			1993	7,689	324	10	769	445	5,831	27
28	Air Conditioner			1995	2,385	240	10	238	(2)	1,232	28
29	Water Softener			1996	500	35	12	42	7	198	29
30	Front Circle Driveway			1998	8,716	735	15	581	(154)	1,549	30
31	Parking Lot, Fuel Tank			1998	21,522	1,875	20	1,076	(799)	2,258	31
32	Water Softener			1998	2,764		12	230	230	537	32
33	Heating/Cooling Unit			1999	8,685	2,147	10	869	(1,278)	1,005	33
34	Roof			2000	15,823	791	20	330	(461)	330	34
35	Water Heaters			2000	5,810	830	15	290	(540)	290	35
36	TOTAL (lines 4 thru 35)				$ 1,502,603	$ 58,334		$ 39,706	$ (18,628)	$ 803,960	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 54,060	$ 5,913	$ 13,595	$ 7,682		$ 201,163	37
38	Current Year Purchases	58,572	26,431	1,614	(24,817)		1,614	38
39	Fully Depreciated Assets	199,730						39
40								40
41	TOTALS	$ 312,362	$ 32,344	$ 15,209	$ (17,135)		$ 202,777	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,824,965	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 90,678	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 54,915	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (35,763)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,006,737	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired		2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	25% Plane & Radio	1982	$ 6,574	$	$ 6,574	52
53	25% Plane Engine	1988	3,394	141	3,394	53
54	25% Storm Scope	1986	2,347		2,347	54
55	Pickup Truck	1979	8,743		8,072	55
56						56
57	TOTALS		$ 21,058	$ 141	$ 20,387	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,288 Description: Copier (4,365) + Computer (753) + Oxygen equip (170)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			501		501
3	Classroom Wages	(a)				
4	Clinical Wages	(b)		2,730		2,730
5	In-House Trainer Wages	(c)		2,250		2,250
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 5,481	$	$ 5,481
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,481			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 39, Col 3	hrs	$	52	$ 3,090	$	52	$ 3,090	1
2	Licensed Speech and Language Development Therapist	Line 39, Col 3	hrs		18	864		18	864	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39, Col 3	hrs		158	8,513		158	8,513	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39, Col 3	# of prescrpts				6,802		6,802	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	228	$ 12,467	$ 6,802	228	$ 19,269	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bohannon Nursing Home # 0016964 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2000 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 488,432	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	260,533		3
4	Supply Inventory (priced at cost)	7,406		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,326		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,606		8
9	Other(specify): A/R - Employees	862		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 769,165	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	275,220		12
13	Land	10,000		13
14	Buildings, at Historical Cost	1,219,792		14
15	Leasehold Improvements, at Historical Cost	282,811		15
16	Equipment, at Historical Cost	333,420		16
17	Accumulated Depreciation (book methods)	(1,412,834)		17
18	Deferred Charges	5,515		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	27,078		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 741,002	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,510,167	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 38,316	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,795		30
31	Accrued Taxes Payable (excluding real estate taxes)	512		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,810		32
33	Accrued Interest Payable	1,002		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,850		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 135,285	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	253,977		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 253,977	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 389,262	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,120,905	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,510,167	$	48

***(See instructions.)**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,016,130	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,016,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	315,035	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(210,260)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 104,775	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,120,905	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,228,596	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,228,596	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,818	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,818	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,122	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,386	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,508	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,269	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,269	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance Refund	1,615	28
28a	Commissions	978	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,593	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,294,784	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	463,940	31
32	Health Care	873,960	32
33	General Administration	389,394	33
	B. Capital Expense		
34	Ownership	158,624	34
	C. Ancillary Expense		
35	Special Cost Centers	33,531	35
36	Provider Participation Fee	55,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,974,899	40
41	**Income before Income Taxes (line 30 minus line 40)****	319,885	41
42	**Income Taxes**	(4,850)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 315,035	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,080	$ 41,317	$ 19.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,238	5,438	90,532	16.65	3
4	Licensed Practical Nurses	13,692	14,556	192,691	13.24	4
5	Nurse Aides & Orderlies	46,853	49,376	391,263	7.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,468	2,632	26,367	10.02	8
9	Activity Director	1,936	2,080	17,900	8.61	9
10	Activity Assistants	1,208	1,201	7,081	5.90	10
11	Social Service Workers	1,976	2,072	20,045	9.67	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,080	21,470	10.32	13
14	Head Cook	5,552	5,962	43,886	7.36	14
15	Cook Helpers/Assistants	9,058	9,289	58,707	6.32	15
16	Dishwashers					16
17	Maintenance Workers	1,248	1,248	12,131	9.72	17
18	Housekeepers	10,824	11,032	71,222	6.46	18
19	Laundry	3,948	4,113	28,702	6.98	19
20	Administrator	1,888	2,080	69,408	33.37	20
21	Assistant Administrator	1,248	1,248	35,510	28.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,949	3,157	32,785	10.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,828	2,080	17,476	8.40	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,722	121,724	$ 1,178,493 *	$ 9.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 4,561	Ln 1, Col 3	35
36	Medical Director	48	3,000	Ln 9, Col 3	36
37	Medical Records Consultant	22	753	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	1,111	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	60	Ln 10a, Col 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,209	Ln 11, Col 3	44
45	Social Service Consultant	32	1,287	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 11,981		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	351	8,421	Ln 10, Col 3	51
52	Nurse Aides	1,016	18,323	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,367	$ 26,744		53

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Bohannon	Asst. Administrator	100	$ 35,510
Lee Bohannon-Smith	Administrator	0	69,408
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,918

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll	$ 5,978
Boyce, Hund & Assoc.	Accounting	13,810
MES of Illinois	Purchasing	6
American Express	Accounting	5,409
Ron Harvey	Marketing	41,030
Three Systems	Computer	3,575
Brad Barkau	Legal	1,135
Benson, LaMear & Rapert	Accounting	360
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 71,303

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,214
Unemployment Compensation Insurance	11,836
FICA Taxes	87,785
Employee Health Insurance	1,783
Employee Meals	962
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	1,583
Employee Incentives	1,865
Less: Employee Insurance	(3,366)
Employee Incentives, Meals	(2,827)
TOTAL (agree to Schedule V, line 22, col.8)	$ 128,835

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,171
Health Care Worker Background Check	
(Indicate # of checks performed 17)	206
IHCA Dues	3,997
Sam's Wholesale Club	75
NFIB Dues	200
INHAA Dues	150
Advertising	3,416
Attached Schedule	(667)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,205)
Yellow page advertising	(211)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,132

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,800
Seminar Expense	692
Administrative Travel	(1,765)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 727

**See instructions.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bohannon Nursing Home # 0016964 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA=3,997-926(Nonallowable)=3,071**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **13**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,081** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.